

A CLINICAL PERSPECTIVE:

**ADDRESSING MENTAL HEALTH, SUBSTANCE
ABUSE, AND CO-OCCURRING ISSUES OF
TRAUMATIC STRESS**



Personal and Occupational Factors Contributing to Symptoms and Treatment of PTSD for the Reservists and National Guard Service Members

Bert Bauer LCSW

Pathways Transition Program



The Citizen Soldier: A Dual Identity

Civilian	Military
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Team Leader County Mobile Crisis Team

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Social Work Provider of behavioral health services for the City Of Atlanta Jail

Research Clinician for Schizophrenia Studies

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A “Lifer” with 37 years as a Army Reserve Soldier

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Graduate: Command and General Staff College



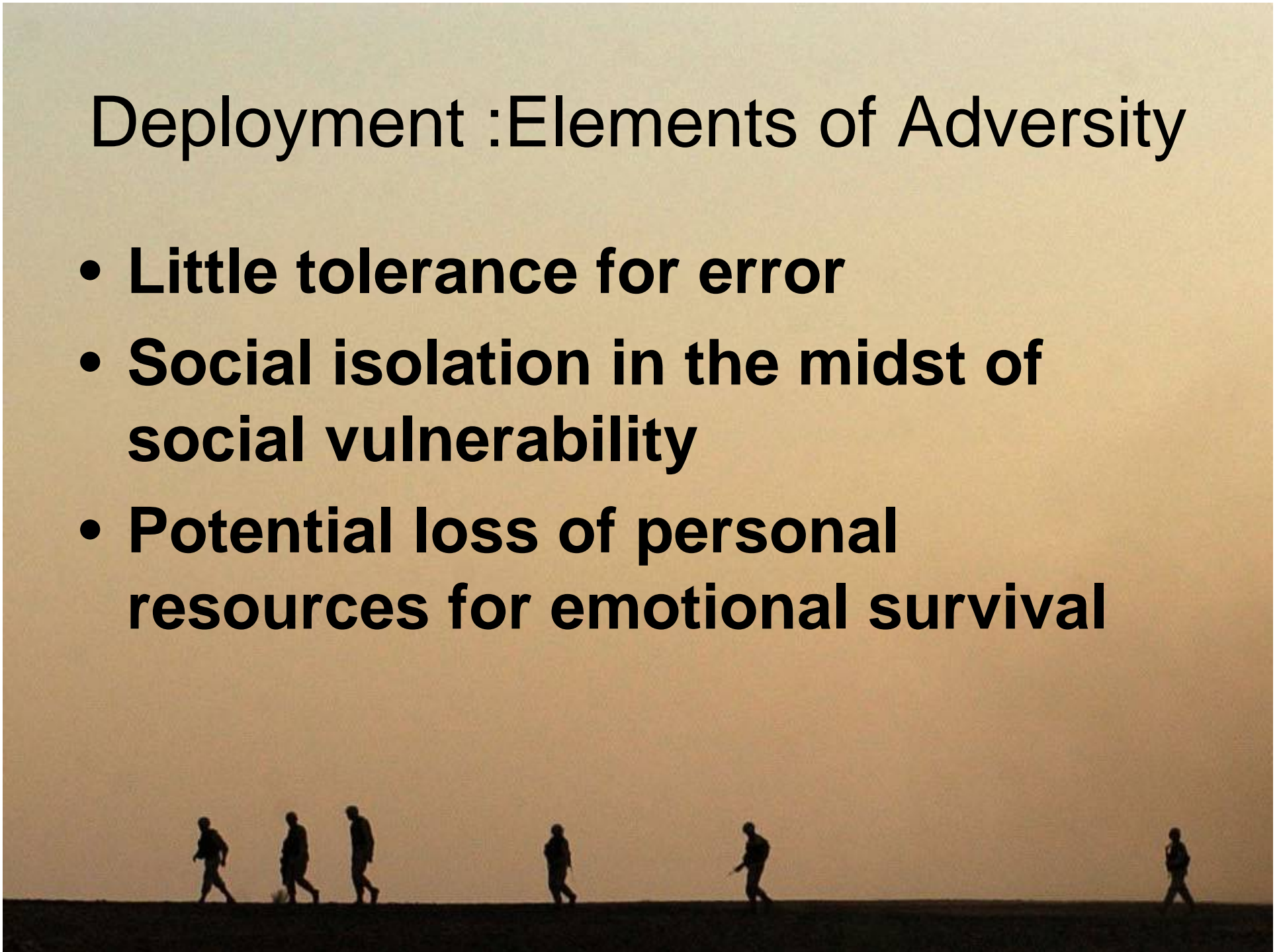
Deployment :Elements of Adversity

- **Harsh Climate**
- **Austere Living Conditions**
- **Social and Emotional Hostility
(Who is your enemy????)**



Deployment :Elements of Adversity

- **Little tolerance for error**
- **Social isolation in the midst of social vulnerability**
- **Potential loss of personal resources for emotional survival**



Cumulative environmental factors contributing to PTSD

Home environment (Civilian)

Deployed environment (Military)



Home Environment (Civilian)

“It is now commonly accepted that PTSD results from an interaction of predisposing genetic and environmental risks that enhance the likelihood of a pathological stress “

Grady Trauma Project

[userwww.service.emory.edu/~kressle/](http://www.service.emory.edu/~kressle/)



Home Environment (Civilian)

Emotional response to the trauma includes subjective trauma severity as well as peri-traumatic dissociation. Covariates include family psychiatric history, substance abuse and dependence, and co-morbid psychiatric diagnoses.

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Deployed Environment (Military)

“Combat stressors do not come from enemy action alone. Many stressors are generated from soldiers own unit leaders and mission demands. If the stressors continue for an extended period, an individual’s adaptive resources become overwhelmed”

Thomas T, O’Hara C.

“Combat Stress in Chechnya: The Equal Opportunity Disorder.”

Army Medical Department Journal. 2000;Jan-Mar.



Clash Of Cultures

Hard Sciences Vs. Behavioral Health Sciences

Medical Services Vs. Medical Support Services

Military Operators Vs. Clinical Services Providers

Garrison Health Care Providers Vs. Health Care Providers in the Field



Lessons Learned From Operation Enduring Freedom and Iraqi Freedom

Multiple operational stressors affect unit morale, cohesion, and behavioral health problems requiring a continuum of care by the entire chain of command.

Prepare AC, RC, NG service member for their austere and difficult deployments with stress management training.



Unique clinical factors confronting reserve and national guard service members:

- **Pre-deployment**
- **Deployment**
- **Post-deployment**



Pre-Deployment

- **Voluntarily giving up established family and community supports to be deployed is potentially a life changing experience.**
- **Can I trust the “system” will take care of my family” while I am deployed?????**
- **Preparing for emotional and physical austerity while separating from a routine of comfort is a behavioral not an intellectual event.**



Deployment

- **Problems created with service members being “cross leveled” into deployed units that are not “their home unit”**
- **Lack of familiarity with the military cultural and coping strategies**
- **Commitment to long term family separations by all is required during deployment.**



Post-Deployment

- **Overlap of emotional and physical symptoms of PTSD**
- **Re-establishment of family, occupational, and community relationships**
- **Diffused and random treatment options for health care**
- **Absence of organizational responsibility of care for the service member. Senior NCOs are the “case managers” of the military during deployment.**



Proposed Treatment Program For Returning “Citizen Soldiers”

- **Joint program between the National Guard Bureau, & Army Reserve Command.**
- **Focus on multiple psychiatric and physical symptoms related to PTSD**
- **Use of individual, group, family, case management modalities with medical oversight.**



“Seamless” Behavioral Health Supports for service member and their family members from the “home unit” to deployment site and back to the home unit to prepare for the next mobilization.

Clinical and administrative Services are funded from Department Of Defense and Health and Human Services appropriations through SAMHSA regional directors to state and regional managers to fund local providers in the community.



Principles of Treatment

Carol Davidson, LCSW, CASAC

Samaritan Village Veterans Program



Samaritan Village Veterans Program

- **History**
- Samaritan Village: 40+ Years of Service
- Development of Residential, Out-Patient & Homeless Services
- Veterans Program founded 1996
- **Client Profile**
- Male Military Veterans: 100%
- Diagnosis of Chemical Dependency: 100%
- Previously Homeless: 100%
- Average Age: 45
- Co-Occurring Health Problems: 50%
- Co-Occurring Mental Health Diagnosis: 70%
- Combat Veterans: 25%



Principles of Treatment con't

- **Connecting**
 - “Welcome Home”
 - Identification & Pride
 - Trust
 - Community
 - Role Modeling
 - Rituals & Pilgrimages



Principles of Treatment

- **Processing**

- Remembering
- Truth Telling
- Witnessing & Honoring
- Rage Release
- Grief Release/Mourning
- Catharsis vs. Retraumatizing



Principles of Treatment con't

- **Affect Regulation**
 - Medication
 - Reframing
 - Skills Building
 - Accountability
 - Individualized Treatment
 - Special Services



Principles of Treatment con't

- **Future Building**
 - Rebuilding of Character
 - Relationships & Belonging
 - Productivity & Purpose
 - Sobriety & Spirituality



Program Model

- 48 Bed Residential Program
- Treatment Stay: 12 months
- Four-Phase Model
- Behavior Modification
- Case Management
- Vocational Development
- Health Services
- Mental Health Services
- Family Services
- Group & Individual Counseling
- Special Topics Groups
- Art Therapy
- EMDR
- Continuing Care



Military Sexual Trauma (MST)

Susan J. McCutcheon, RN, EdD

Office of Mental Health Services

Department of Veterans Affairs



What is Sexual Trauma

- **Military Sexual Trauma (MST)** has been defined by the Department of Veterans Affairs as:
- sexual harassment *that is threatening in character or*
- physical assault of a sexual nature *that occurred while the victim was in the military*



Timeline of Events Related to Military Sexual Trauma

- 1991 – Tail hook incident: brought MST to public attention
- 1992 – Senate hearing about MST
 - Public Law 102-585: health care services for women who experience MST, and other provisions
- 1994 – Public Law 103-452: extended law to include men who experience MST
- 1997 - Letter from Secretary Jesse Brown to all women veterans regarding MST
- 1999 – Public Law 106-117: extended duration of MST program
- 2004 – Public Law 108-422: permanent authority for MST program



Prevalence

- Based on the VA's MST screening data from FY 2002 – FY 2005:
- 20% of women have experienced MST
- 1% of men have experienced MST
- Even though MST is far more common in women, 52% of all VA patients who screen positive for MST are **men**

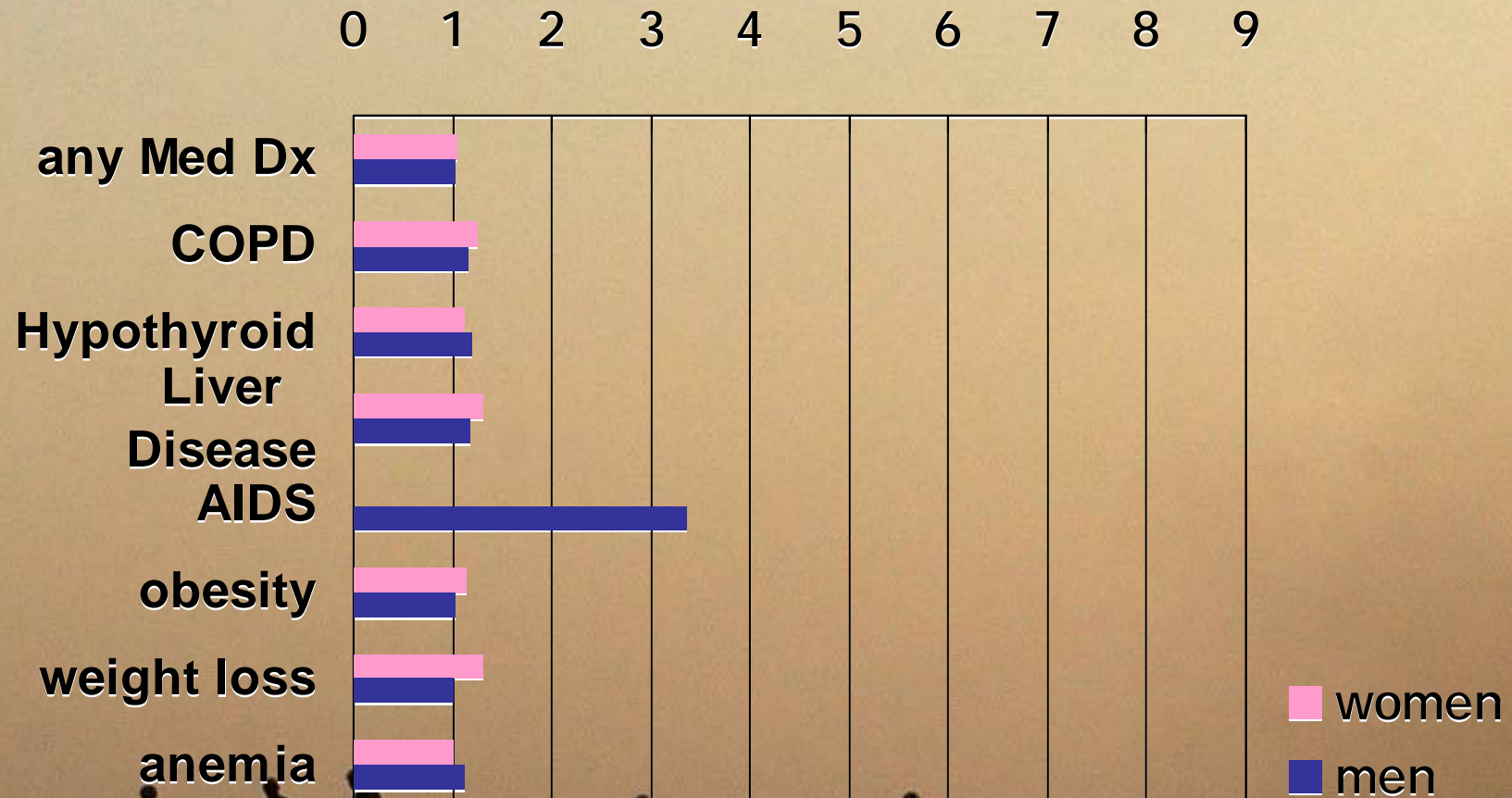


Eligibility for treatment

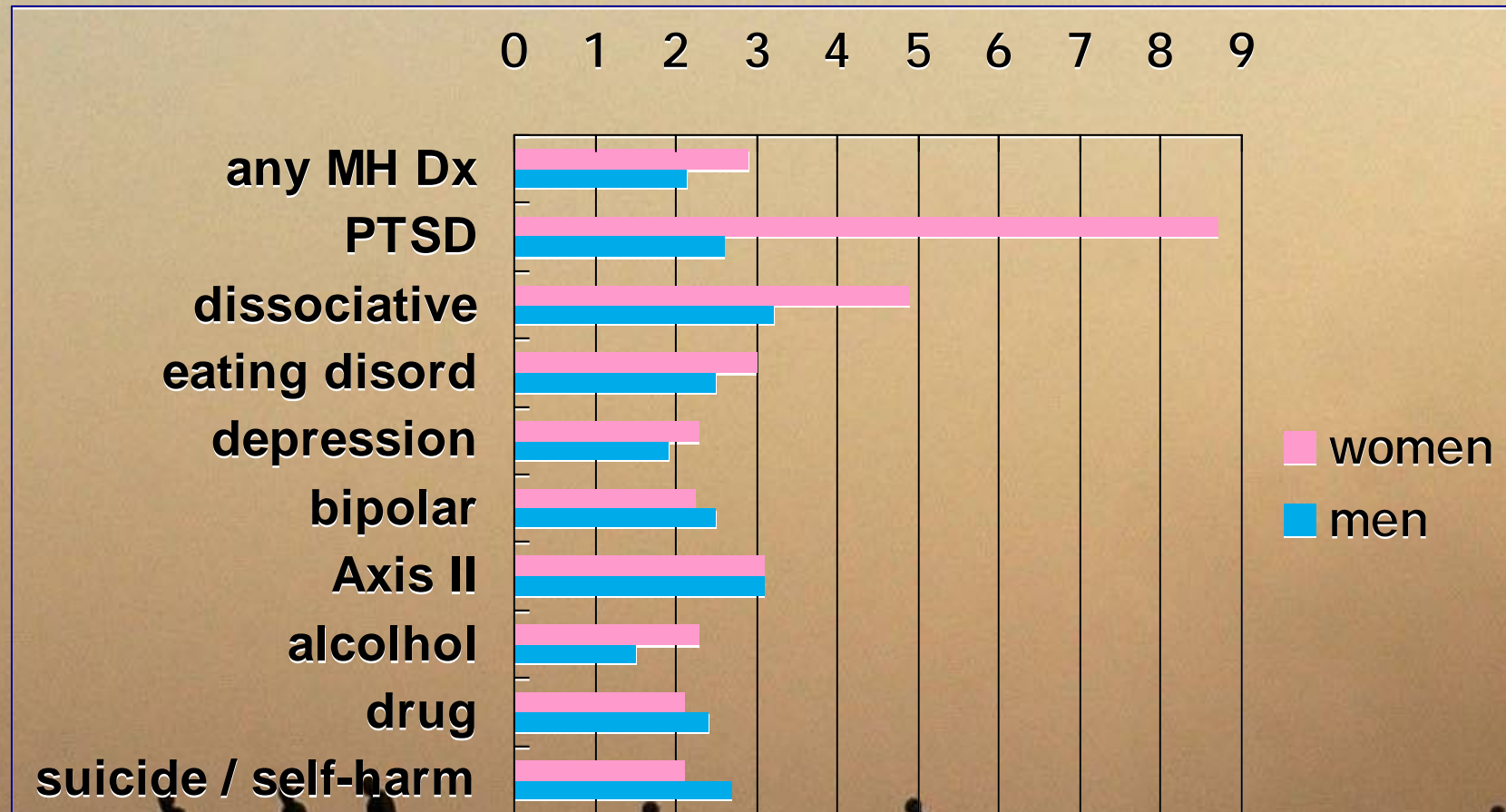
- Any veteran who believes he/she experienced MST can apply at any VA medical facility (VAMC), Readjustment Counseling Service (Vet Center) or Veterans Benefit Office (VBA) for counseling and treatment of any MST-related injury, illness, or psychological condition, without obligation for co-payment.
- Reservists and members of National Guard units who were activated to full-time status in the Armed Forces are also eligible.
- MST Counseling can be provided ***even if a veteran did not report the incident when it occurred***



Odds of Diagnosis as a Function of MST



Odds of Diagnosis as a Function of MST



Risk Factors

- Female
- Age 19 or younger at time of enlistment
- Experienced childhood physical or sexual violence
- Enlisted rank



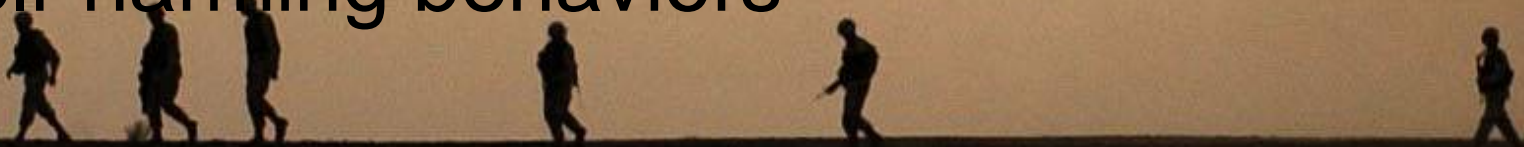
Sexual Assault in the Military Environment: Factors to Consider

- Power differential
- Career concerns
- Violation of trust
- Contact with abuser
- Reporting issues
- Cohesion of the unit
- Homophobia



MST – Common Reactions

- Loss of control
- Fear
- Re-experiencing
- Avoidance
- Numbing
- Distorted perception of self
- Relationship problems
- Physical problems
- Self-harming behaviors



MST Interventions

- Medication
- Cognitive-Behavioral Therapy (CBT) / Exposure Therapy
- Coping Skills / Symptom Management



Effective Treatment for “Complex PTSD”

- “Complex PTSD” or “Disorder of Extreme Stress” may occur if a victim of MST was also exposed to prolonged, repeated traumatic experiences, like sexual or physical abuse during childhood.
- Dialectical Behavior Therapy (DBT) has been shown to be effective with this type of symptomatology



Risk for Revictimization

- Revictimization – patients who have experienced violence once are more likely to experience violence repeatedly
- People with MST have a higher risk of having experienced other forms of violence in the past
- People with MST are also at higher risk of experiencing interpersonal violence again in the future



Military Sexual Trauma

- For more information:
<http://www.va.gov/vhi>
MST training program and materials
- Each VA facility has a MST Coordinator that can assist you with screening, referrals, and eligibility questions



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